EXHIBIT A

Margaret Craig v. Cheatham County, Tennessee, et al.

Dr. Rathel Nolan

May 21, 2019

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A. The earliest records I have were after she had an apparent overdose on benzodiazepine. So I have nothing prior to that.

Q. The first thing in your report is a discussion of her treatment at Gateway on September 30, 2016. Are those the oldest records that you've been given to review?

A. Yes.

Q. So as far as that initial treatment at Gateway, just going through your report, Ms. Hulsey was admitted to the hospital for an overdose on narcotics, correct?

A. Yes.

Q. You have the drug screen was positive for benzodiazepines, opiates, methamphetamine and cannabis, correct?

A. Yes.

Q. And is it your understanding that Ms. Hulsey had a lengthy history of drug use, including intravenous drug use?

A. I would presume so, yes.

Q. And the multiple needle track marks on her skin were consistent with IV drug use; is that correct?

A. Yes.

Q. So when she got to the hospital she had urine and blood cultures taken at some point, correct?
A. Yes.
Q. She had been admitted to the hospital at 4:19 p.m. on September 30, 2016?
A. Yes.
Q. And those urine and blood cultures were still pending at the time of her discharge roughly 17 hours later?
A. They were not finalized. That's correct.
Q. What does that mean for them to be finalized?
A. Well, the attending physician said that she had gram-positive cocci in her blood. And that narrows down the number of things that it could be, but they had not identified it as staphylococcus aureus yet.
Q. How long does that usually take to get that final result?
A. It depends on the technique you're using. But conventional technique 48 to 72 hours.
Q. All right. So Ms. Hulsey left that facility against medical advice on October 1, 2016, correct?

A. Yes.
Q. But it looks, from the records, that her treating physician knew enough to be concerned about her leaving when she did, correct?
A. Yes.
Q. Why is that?
A. Well, because she has a history of IV drug use and because she had the gram-positive cocci in her blood stream, it's a fairly common thing for drug abusers to have just what she had, which is endocarditis. So there would be a concern that she was bacteremic from something like staphylococcal endocarditis or some other infections. Sometimes they get joint infections when they inject into the joints. So yes, it was a concern.
Q. What does it mean to be bacteremic?
A. It means they have -- physically have bacteria in your blood stream.
Q. Is that -- are these two separate issues, being bacteremic and the endocarditis?
A. No. Endocarditis is a cause of bacteremia, but it's not the only cause of bacteremia.
Q. Describe what endocarditis is if you would?

A. Well, endocarditis is an infection on one of the valves of the heart. And I don't know how much of a description you want. But you have a little blood clot that forms on the heart. And those probably form normally and dissolve normally in every one every day. But you get a clot on the heart valve and the bacteria get into that clot and they tend to grow. The clot gets bigger and people -- as the heart beats, the valve opens and closes and it flicks the bacteria out into the circulation. So you have the bacteria in the blood stream and it can travel other places.

With her kind of endocarditis it would be the lungs, which it apparently did. And eventually it will eat up and destroy the heart valve, which can have some hemodynamic consequences. It didn't really in her because she had a tricuspid valve endocarditis, which is a less important valve to your health and well-being than some of the others.

That's probably more of an explanation than you wanted, but...

Q. No, that's fine.

Was she more at risk of developing endocarditis because of her chronic IV drug use?

A. Yes, she was. Because that's a bacteria

that exists on the skin. And when you stick a needle in your arm into a vein you risk dragging the bacteria onto the needle and into the blood stream.

Q. Can you tell from the results how long she had that infection when it was finally -- when the results of her blood urine work were finalized?

A. During this admission or during her terminal admission?

Q. During this admission?

A. No, you really can't.

Q. Does the physician, treating physician need those final results from the blood and urine analysis in order to make the diagnosis of endocarditis?

A. Well, the -- that's part of it, yes. But you need to show the blood clot, the vegetation on the heart valve. And that was not done before she left against medical advice.

So during her terminal admission they did get the echocardiogram that showed that. It was highly suspicious for that. If she had stayed around they would have sorted that out.

Q. Had she stayed around?

A. Yes.

Q. But you believe that she had endocarditis

as of that admission to Gateway Medical Center of September 30, 2016?

A. Probably, yes.

Q. And at some point did they administer antibiotics intravenously to her during that hospital stay?

A. Yes, they did.

Q. Okay. I take it according to what her treating physician wrote in the discharge note she needed at least 24 hours of inpatient care or more, correct?

A. Yes. That's kind of rogue statement for Medicare, but, yes.

Q. She probably would have needed much more inpatient treatment than 24 hours, would she not?

A. Yes.

Q. What's the typical length of IV antibiotic treatment for someone with the infection that she had?

A. For her -- well, it's kind -- I'm going to make it a complicated question. It's a common infection in IV drug users. And typically for staphylococcal endocarditis you're going to treat for at least four weeks of intravenous antibiotics. IV antibiotics and intravenous drug users is

difficult, so there are some shorter course oral therapies that are given. But in the best of all possible worlds, there would have been four weeks of intravenous antibiotics.

Q. That she would have received on an inpatient basis?

A. She -- well, she could have -- yeah, again it's complicated. If she wasn't an IV drug user you could send her home on IV antibiotics when she was stabilized. But because she likes to put things into IVs you probably wouldn't want to have done that. So she probably would have been inpatient for four weeks or some other arrangements would have been made.

Q. So whatever IV antibiotic therapy she received before she left against medical advice would not have been enough to cure her infection, correct?

A. No, it would not have been.

Q. And then is there any guarantee that even if she had stayed at Gateway for four weeks of antibiotic therapy that that would have cleared up the infection?

A. Well, you can't guarantee anybody an outcome. But more likely than not it would have

Q. Was she extremely ill as of September 30, 2016?
A. Yes.
Q. What do you mean by extremely ill?
A. She had a life-threatening infection. Staphylococcal endocarditis is a bad actor and you tend to kind of -- people rock on with it for a while, but untreated it's -- endocarditis untreated is a hundred percent fatal. You just have to -- it just depends on how long it takes.
Q. You also put in your report, "It's safe to assume that her severe illness would have been apparent to the most casual observer." That's the sentence after the October 6th incarceration. Are you referring to October 6, 2016 in that sentence?
A. Yes.
Q. Would her illness have been apparent to a casual observer as of September 30, 2016?
A. Well, probably. I would have to look back specifically at that in the records. Because you have people who are not casual observers who saw her. And I would be interested to see if any of the physicians or other providers made comments about she looks sick. Yeah, I think she would have looked sick. She would have looked chronically ill then

too long. But it's complicated also by her IV drug use and her other substance abuse. Because those folks tend to look ill anyway. Because if you've used drugs a bunch then sometimes you don't -- methamphetamine, you don't sleep for days. That makes you look bad. You have less attention to your personal hygiene. Your diet goes to hell. People don't eat very well when they're taking stimulant drugs like methamphetamine.

So, yeah, she may have looked sick for a long time. So that's probably -- I'm sorry, I'm rambling. I'm just thinking out loud and rambling.

Q. A person's physical appearance who has bacteremia would be similar to the physical appearance of an IV drug user; is that a fair statement?

A. It could be, yes. That's such a broad generalization, but it could be.

Q. How do you differentiate between whether someone's got bacteremia or is an IV drug user?

A. Blood cultures.

Q. One more question going to back the sentence that says, "Although I was, of course, not present it's safe to assume that her severe illness would have been apparent to the most casual

So looking at somebody you may be able to suspect that. But in and of itself, just looking at somebody, no, you can't tell that they're bacteremic.

Q. Is that for a medical professional, just looking at someone wouldn't be able to tell that they're bacteremic?

A. No, you could not.

Q. Same goes for a layperson? A layperson could not look at someone and be able to tell that that person is bacteremic, correct?

A. Not anyone I've ever heard of.

Q. So then Ms. Hulsey went to Centennial Medical Center two days later on October 3, 2016, correct?

A. Yes.

Q. And her complaint at that time was drooping on the left side of her face for two days, correct?

A. Yes.

Q. And she was diagnosed with Bell's Palsy, correct?

A. That's what they said.

Q. Okay. Following up on what you just said, do you question that diagnosis?

doctor disconnect and...

She had an elevated serum creatinine when she was seen there, which is a marker for a kidney injury. But during her final admission her creatinine had declined almost towards normal. So I'm not sure what to make of that. I think that was probably dehydration and not a direct affect on the kidneys. But at that point about the only way you could tell is by autopsy.

Q. I'm reading from the bottom of the third page of your letter to Mr. Moseley.

A. Yeah. Third page? Let's see. Yeah, and I'm going to have to back pedal on that. Because that could have been -- after reading the records a couple more times -- that could have been because of spread to the kidneys. But because her renal function was better and almost normal during her admission following her incarceration, I'm not sure about that.

Q. But you still think that by October 3rd the infection had spread to her brain, correct?

A. Yes. That is the most plausible explanation for her facial drooping.

Q. That she had a stroke? Did she have a stroke, in your opinion?

A. No. She may have had an abscess that was acting the same way a stroke would act. So again, I get into my semantical stuff, is that a stroke? It's a stroke-like illness, yes.

Q. But it does not appear at any time during the October 3, 2016 treatment at Centennial that she was ever diagnosed as being bacteremic, correct?

A. Correct. But I would add that she had a low platelet count and a high white count and a creatinine of three and a half and a high white count anemic. And any one of those things were a reason enough to put her in the hospital.

Q. Yeah. But for whatever reason even with all those lab results, the treating physician did not diagnose her as being bacteremic or want to admit her to the hospital, correct?

A. That's correct.

Q. And then turning to -- she was detained beginning on October 6, 2016. Once she was detained in the jail and would not have had access to drugs, would you have expected her to experience withdrawal symptoms?

A. I wouldn't have been surprised. I don't know that I would have expected it. But she was using so many different things -- yeah, I mean, she

could have been habituated to any number of things or she might not have been. It's just hard to predict. Again, I don't have the records previously. We don't have much of an account of how much she took of what. So yeah, I wouldn't have been surprised. I don't know if I would have expected it.

Q. When would those symptoms of withdrawal usually have started?

A. Which drug are we talking about?

Q. Let's start with opiates.

A. Now, I'm going to be getting out of my depth. Probably within about two of three days after she's absent for opiates.

Q. What about benzodiazepines?

A. Depends on if she's been using long-acting or short-acting benzodiazepines. Some of them get out of your system pretty quickly. And some of them hang around for a long time. So it can go from a couple of days to a week or so.

Q. What about methamphetamine? How long would you have expected her to start experiencing withdrawal symptoms?

A. Again, I'm getting out of my depth with this because that's not something I do on a daily

basis. Probably about 72 hours.
Q. If she was experiencing symptoms withdrawal from the drugs she had been taking, what signs and symptoms would you have expected to see?
A. Again, that varies from medication to medication and -- from drug of abuse to drug of abuse, I'm sorry. Because stimulant drugs, when you get off of them -- like methamphetamine is a stimulant drug. And when you quit taking that, it's like fatigue, depression and somnolence. And then when you quit taking benzodiazepines then it's sort of the opposite. You're off the depressive medication and you have more excitably. It can induce seizures. Then narcotic withdrawals are more agitation, diarrhea, sweating, things of that nature.
Q. Would you expect someone to experience flu like symptoms who's experiencing drug withdrawals?
A. Broadly sure. You wouldn't feel good.
Q. Would you expect someone who was bacteremic like Ms. Hulsey was to experience flu like symptoms?
A. Yes. Yeah, if it's severe -- broadly, yes, it would be some of that.
Q. So when she came to the jail -- or

whenever she started experiencing symptoms of withdrawal when she was in jail, those symptoms would have looked similar to someone who was bacteremic; is that fair?

A. It could have.

Q. We've already discussed a layperson wouldn't be able to look at Ms. Hulsey when she's in the jail and be able to discern whether the symptoms she was demonstrating were consistent with drug withdrawals or bacteremia, correct?

A. Well, are we talking about -- through her entire incarceration were two things. One, she was incontinent of stool. And that generally gets anybody attention when she's defecating on herself. And then she had a seizer-like episode and had no history of prior seizure-like episodes. And I'll grant you the rest, that it would be hard to tell. But once she had these seizure-like episodes, she needed to be transferred to a hospital. That should have been obvious. That she needed to be evaluated by a physician.

Q. So the incontinence, is that related to bacteremia or to drug withdrawals or both?

A. Don't know. It's not a common finding and -- it's not something that, you know, you say

deposition testimony that Ms. Hulsey -- "She had what appeared to me as a seizure." Correct?

A. Yes.

Q. Okay. If -- obviously you didn't witness what happened, correct?

A. Oh, obviously not. Yes.

Q. Can you make a diagnosis that someone has suffered a seizure based just on what Ms. Durham testified that appeared to her to be a seizure?

A. Well, it's not really pertinent to my opinion. But no I couldn't third-handedly do so.

Q. Okay. Same thing, you couldn't -- if Ms. Newman were to testify that she saw what appeared to her to be a seizure, you couldn't make a diagnosis that a person suffered from a seizure based just on what Ms. Newman said, correct?

A. Correct.

Q. You don't -- you don't rely on a layperson's characterization of a medical event in making a diagnosis, correct?

A. Not solely, but you certainly take those things into account. I mean, whenever you make a diagnosis you're usually talking to a layperson.

Q. Right. But you -- there could have other things that would have explained whatever this